CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 10:830. Acute care inpatient hospital reimbursement.

RELATES TO: KRS 13B.140, 142.303, 205.510(16), 205.565, 205.637, 205.638, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.250-447.280, 42 U.S.C. 1395f(l), 1395ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4, Pub.L. 111-148

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.640(1), 205.641(2), 216.380(12), 42 C.F.R. 447.200, 447.250, 447.252, 447.253, 447.271, 447.272, 42 U.S. C. 1396a, 1396r-4

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the Department for Medicaid Services' reimbursement provisions and requirements for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization.

Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

(2) "Appalachian Regional Hospital System" means a private, not-for-profit hospital chain operating in a Kentucky county that receives coal severance tax proceeds.

(3) "Capital cost" means capital related expenses including insurance, taxes, interest and depreciation related to plant and equipment.

(4) “CMS" means the Centers for Medicare and Medicaid Services.

(5) “CMS IPPS Pricer Program” means the software program published on the CMS website of http://www.cms.hhs.gov which shows the Medicare rate components and payment rates under the Medicare inpatient prospective payment system for a discharge within a given federal fiscal year.

(6) "Cost outlier" means a claim for which estimated cost exceeds the outlier threshold.

(7) "Critical access hospital" or "CAH" means a hospital:

(a) Meeting the licensure requirements established in 906 KAR 1:110; and

(b) Designated as a critical access hospital by the department.

(8) "Department" means the Department for Medicaid Services or its designated agent.

(9) “Diagnosis code” means a code:

(a) Maintained by the Centers for Medicare and Medicaid Services (CMS) to group and identify a disease, disorder, symptom, or medical sign; and

(b) Used to measure morbidity and mortality.

(10) “Diagnosis related group” or “DRG” means a clinically similar grouping of services that can be expected to consume similar amounts of hospital resources.

(11) "Distinct part unit" means a separate unit within an acute care hospital that

meets the qualifications established in 42 C.F.R. 412.25 and is designated as a distinct part unit by the department.

(12) “DRG base payment” means the sum of the operating base payment and capital base payment, calculated as described in paragraphs (4)(b) through (4)(c) of section 2 of this administrative regulation.

(13) “DRG geometric mean length-of-stay” means an average hospital length-of-stay, expressed in days, for each DRG. The geometric mean is calculated by taking the nth (number of values in the set) root of the product of all length-of-stay values within a given DRG.

(14) "Enrollee" means a recipient who is enrolled with a managed care organization.

(15) "Enrollee day" means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.

(16) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(17) "Fixed loss cost threshold" means an amount, established annually by CMS, which is combined with the full DRG payment or transfer payment for each DRG to determine the outlier threshold.

(18) "Government entity" means an entity that qualifies as a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

(19) "Hospital-acquired condition" means a condition:

(a)1. Associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D); and

2. Not present upon the recipient’s admission to the hospital; and

(b) Which is recognized by the Centers for Medicare and Medicaid Services as a

hospital acquired condition.

(20) “Indirect Medical Education Costs” means additional costs of serving Medicaid recipients, incurred by teaching hospitals, to provide training and education to interns and residents, which are not reimbursed through direct graduate medical education payments.

(21) "Long-term acute care hospital" means a long term care hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(22) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(23) "Medicaid fee-for-service" means a service associated with a Medicaid recipient who is not enrolled with a managed care organization.

(24) "Medicaid fee-for-service covered day" means an inpatient hospital day associated with a Medicaid recipient who is not enrolled with a managed care organization.

(25) "Medicaid shortfall" means the difference between a provider’s allowable cost of providing services to Medicaid recipients and the amount received in accordance with the payment provisions established in Section 2 of this administrative regulation.

(26) "Medical education costs" means direct and allowable costs that are:

(a) Associated with an approved intern and resident program; and

(b) Subject to limits established by Medicare.

(27) "Medically necessary" or "medical necessity" means that a covered benefit shall be provided in accordance with 907 KAR 3:130.

(28) “Medicare-dependent hospital” means a hospital designated as a Medicare de-

pendent hospital by the Centers for Medicare and Medicaid Services.

(29) “Medicare operating and capital cost-to-charge ratios” means two hospital-specific calculations completed by Medicare using CMS 2552 cost report information. Medicare operating costs are divided by total applicable charges to determine a Medicare operating cost-to-charge ratio. Medicare capital costs are divided by total applicable charges to determine a Medicare capital cost-to-charge ratio. These ratios are published annually by CMS in an impact file released with the Medicare IPPS final rule for a given federal fiscal year.

(30) "Never event" means:

(a) A procedure, service, or hospitalization not reimbursable by Medicare pursuant to CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101; or

(b) A hospital-acquired condition.

(31) "Outlier threshold" means the sum of the DRG base payment or transfer payment and the fixed loss cost threshold.

(32) "Pediatric teaching hospital" is defined in KRS 205.565(1).

(33) "Per diem rate" means the per diem rate paid by the department for:

(a) Inpatient care in an in-state psychiatric or rehabilitation hospital;

(b) Inpatient care in a long-term acute care hospital;

(c) Inpatient care in a critical access hospital,

(d) Psychiatric, substance use disorder, or rehabilitation services in an in-state acute care hospital which has a distinct part unit; or

(e) A psychiatric or rehabilitation service in an in-state acute care hospital.

(34) "Psychiatric hospital" means a hospital which meets the licensure requirements as established in 902 KAR 20:180.

(35) "Quality improvement organization" or "QIO" means an organization that complies with 42 C.F.R. 475.101.

(36) "Rehabilitation hospital" means a hospital meeting the licensure requirements as established in 902 KAR 20:240.

(37) “Relative weight” means the factor assigned to each Medicare DRG classification that represents the average resources required for a Medicare DRG classification paid under the DRG methodology relative to the average resources required for all DRG discharges paid under the DRG methodology for the same period.

(38) "Resident" means an individual living in Kentucky who is not receiving public assistance in another state.

(39) "Rural hospital" means a hospital located in a rural area pursuant to 42 C.F.R. 412.64(b)(1)(ii)(C).

(40) “Sole community hospital” means a hospital that is currently designated as a sole community hospital by the Centers for Medicare and Medicaid Services.

(41) "State university teaching hospital" means:

(a) A hospital that is owned or operated by a Kentucky state-supported university with a medical school; or

(b) A hospital:

1. In which three (3) or more departments or major divisions of the University of Kentucky or University of Louisville medical school are physically located and which are used as the primary (greater than fifty (50) percent) medical teaching facility for the

medical students at the University of Kentucky or the University of Louisville; and

2. That does not possess only a residency program or rotation agreement.

(42) "Transfer payment" means a payment made for a recipient who is transferred to or from another hospital for a service reimbursed on a prospective discharge basis.

(43) "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School.

(44) “Universal rate year” means the twelve (12) month period under the prospective payment system, beginning October of each year, for which a payment rate is established for a hospital regardless of the hospital’s fiscal year end.

(45) "Urban hospital" means a hospital located in an urban area pursuant to 42 C.F.R. 412.64(b)(1)(ii).

(46) "Urban trauma center hospital" means an acute care hospital that:

(a) Is designated as a Level I Trauma Center by the American College of Surgeons;

(b) Has a Medicaid utilization rate greater than twenty-five (25) percent; and

(c) Has at least fifty (50) percent of its Medicaid population as residents of the county in which the hospital is located.

Section 2. Payment for an Inpatient Acute Care Service in an In-state Acute Care Hospital. (1)(a) The department shall reimburse an in-state acute care hospital for an inpatient acute care service, except for a service not covered pursuant to 907 KAR 10:012, on a fully-prospective per discharge basis.

(b) The department’s reimbursement pursuant to this administrative regulation shall approximate ninety-five (95) percent of a hospital’s Medicare reimbursement excluding

the following Medicare reimbursement components:

1. A Medicare low-volume hospital payment;

2. A Medicare end stage renal disease payment;

3. A Medicare new technology add-on payment;

4. A Medicare routine pass-through payment;

5. A Medicare ancillary pass-through payment;

6. A Medicare value-based purchasing payment or penalty;

7. A Medicare readmission penalty in accordance with paragraph (c) of this subsection;

8. A Medicare hospital-acquired condition penalty in accordance with paragraph (c) of this subsection;

9. Any type of Medicare payment implemented by Medicare after October 1, 2015; or

10. Any type of Medicare payment not described in this administrative regulation.

(c) The department's:

1. Never event and hospital-acquired condition provisions established in Section 3 of this administrative regulation shall apply to acute care inpatient hospital reimbursement under this administrative regulation; and

2. Readmission provisions established in Section 12 of this administrative regulation shall apply shall apply to acute care inpatient hospital reimbursement under this administrative regulation.

(2)(a) For an inpatient acute care service, except for a service not covered pursuant to 907 KAR 10:012, in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:

1. A DRG base payment; and

2. If applicable, a cost outlier payment.

(b) The resulting payment shall be limited to ninety-five (95) percent of the calculated value.

(c) If applicable, a transplant acquisition fee payment shall be added pursuant to subsection (11)(b) of this section.

(3)(a) The department shall assign a DRG classification to each unique discharge billed by an acute care hospital.

(b)1. The DRG assignment shall be based on the most recent Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services beginning with version thirty-two (32) upon adoption of this regulation.

2. The grouper version shall be updated in accordance with Section 8 of this administrative regulation.

(c) In assigning a DRG for a claim, the department shall exclude from consideration any secondary diagnosis code associated with a never event.

(4)(a) A DRG base payment shall be the sum of the operating base payment and the capital base payment calculated as described in paragraphs (c) through (d) of this subsection.

(b) All calculations in this subsection are subject to special rate-setting provisions for sole community hospitals and Medicare dependent hospitals as described in sections 5 and 6 of this administrative regulation.

(c)1. The operating base payment shall be determined by multiplying the hospital-specific operating rate by the DRG relative weight.

2. If applicable, the resulting product of subparagraph 1. of this paragraph shall be multiplied by the sum of one (1) and a hospital-specific operating indirect medical education (IME) factor determined in accordance with subparagraph 7 of this paragraph.

3. Upon adoption of this regulation, the hospital-specific operating rate referenced in subparagraph 1 of this paragraph shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS final rule data tables published by CMS as described in subparagraphs 4 through 6 of this paragraph.

4. The Medicare IPPS standard amount established for operating labor costs shall be multiplied by the wage index associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare.

5. The resulting product of subparagraph 4 of this paragraph shall be added to the Medicare IPPS standard amount for non-labor operating costs.

6. The operating rate shall be updated in accordance with Section 8 of this administrative regulation.

7.a. Upon adoption of this regulation, the hospital-specific operating IME factor shall be taken from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) final rule impact file published by CMS.

b. The operating IME factor shall be updated in accordance with Section 8 of this administrative regulation.

(d)1. The capital base payment shall be determined by multiplying the hospital-specific capital rate by the DRG relative weight.

2. If applicable, the resulting product of subparagraph 1. of this paragraph shall be

multiplied by the sum of one (1) and a hospital-specific capital indirect medical education factor determined in accordance with subparagraph 6 of this paragraph.

3. Upon adoption of this regulation, the hospital-specific capital rate referenced in subparagraph 1 of this paragraph shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS final rule data tables published by CMS as described in subparagraphs 4 and 5 of this paragraph.

4. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.

5. The capital rate shall be updated in accordance with Section 8 of this administrative regulation.

6.a. Upon adoption of this regulation, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) final rule impact file published by CMS.

b. The capital IME factor shall be updated in accordance with Section 8 of this administrative regulation.

(5)(a) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG.

(b) A cost outlier shall be subject to QIO review and approval.

(c) A discharge shall qualify for a cost outlier payment if its estimated cost exceeds the DRG’s outlier threshold.

(d)1. The department shall calculate the estimated cost of a discharge:

a. For purposes of comparing the discharge cost to the outlier threshold; and

b. By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

2.a. Effective October 1, 2015 a Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS final rule impact file published by CMS.

b. The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Section 8 of this administrative regulation.

(e)1. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

2.a. Upon adoption of this regulation the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.

b. The fixed loss cost threshold shall be updated in accordance with Section 8 of this administrative regulation.

(f)1. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

2. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

(6)(a) Effective October 1, 2015, the department shall establish DRG relative weights obtained from the Medicare IPPS final rule data tables corresponding to the grouper version in effect under subsection (3) of this section.

(b) Relative weights shall be revised to match the grouping software version for updates in accordance with Section 8 of this administrative regulation.

(7) The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

(8)(a) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

(b) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

(c)1. The department shall calculate an average daily discharge rate by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.

2. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS final rule data tables corresponding to the grouper version in effect under subsection (3) of this section.

3. The geometric length-of-stay values shall be revised to match the grouping software version for updates in accordance with Section 8 of this administrative regulation.

(d) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

(e) For a hospital receiving a transferred patient, the department shall reimburse the full DRG base payment and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

(9)(a) The department shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs in accordance with paragraphs (a) through (d) of this subsection as a post-acute care transfer.

(b) The following shall qualify as a post-acute care setting.

1. A skilled nursing facility;

2. A cancer or children's hospital;

3. A home health agency;

4. A rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;

5. A long-term acute care hospital; or

6. A psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.

(c) A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).

(d)1. The department shall pay each transferring hospital an average daily rate for each day of a stay.

2. A transfer-related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

3. A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay up to the full DRG base payment.

4. A DRG that is referenced in paragraph (b) of this subsection and not referenced in

subparagraph 2 of this paragraph shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.

5. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

(e)1. The average daily rate shall be the base DRG payment allowed divided by the Medicare geometric mean length-of-stay for a patient's DRG classification.

2. The Medicare geometric mean length-of-stay shall be determined and updated in accordance with subsection (8)(a)(1) of this section.

(10) The department shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815, for each day the patient remains in the distinct part unit.

(11)(a) The department shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.

(b)1. The department's organ transplant reimbursement shall include an interim reimbursement followed by a final reimbursement.

2. The final reimbursement shall:

a. Include a cost settlement process based on the Medicare 2552 cost report form; and

b. Be designed to reimburse hospitals for ninety-five (95) percent of organ acquisition costs.

3.a. An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the rates established in subclauses (i), (ii), (iii), (iv), and (v) of this clause:

(i) Kidney Acquisition - $65,000;

(ii) Liver Acquisition - $55,000;

(iii) Heart Acquisition - $70,000;

(iv) Lung Acquisition - $65,000; or

(v) Pancreas Acquisition - $40,000.

b. Upon receipt of a hospital's as-filed Medicare cost report the Department shall calculate a tentative settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified in subparagraph 3.a. of this paragraph.

c. Upon receipt of a hospital's finalized Medicare cost report the Department shall calculate a final reimbursement which shall be a cost settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified in clause a of this subparagraph.

d. The final cost settlement shall reflect any cost report adjustments made by CMS.

Section 3. Never Events. (1) For each diagnosis on a claim a hospital shall specify on the claim whether the diagnosis was present upon the individual's admission to the hospital.

(2) In assigning a DRG for a claim the department shall exclude from the DRG assignment consideration of any secondary diagnosis code associated with a hospital-acquired condition.

(3) A hospital shall not seek payment for treatment for or related to a never event through:

(a) A recipient;

(b) The Cabinet for Health and Family Services for a child in the custody of the cabinet; or

(c) The Department for Juvenile Justice for a child in the custody of the Department for Juvenile Justice.

(4) A recipient, the Cabinet for Health and Family Services, or the Department for Juvenile Justice shall not be liable for treatment for or related to a never event.

Section 4. Preadmission Services for an Inpatient Acute Care Service. A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

(1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and

(2) Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Section 5. Reimbursement for Sole Community Hospitals. An operating rate for sole community hospitals shall be calculated as described in subsections (1) and (2) of this section.

(1)(a) For each sole community hospital the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.

(b) On October 1, 2015, the HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS final rule impact file.

(c) Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Section 8 of this administrative regulation.

(2)(a) The department shall compare the rate referenced in subsection (1) of this section with the operating rate calculated in section 2(4)(c) of this administrative regulation.

(b) The higher of the two (2) rates shall be utilized as the operating rate for sole community hospitals.

Section 6. Reimbursement for Medicare Dependent Hospitals. (1)(a) For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.

(b) On October 1, 2015, the HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS final rule impact file.

(c) Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Section 8 of this administrative regulation.

(2)(a) The department shall compare the rate referenced in subsection (1) of this section with the operating rate calculated in section 2(4)(c) of this administrative regulation.

(b) If the section 2(4)(c) rate is higher, it shall be utilized as the hospital's operating rate for the period.

(c)1. If the rate referenced in paragraph (a) is of this subsection is higher, the department shall calculate the arithmetic difference between the two rates.

2. The difference shall be multiplied by seventy-five (75) percent.

3. The resulting product shall be added to the section 2(4)(c) rate to determine the hospital's operating rate for the period.

(d) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in section 2(4)(c) of this administrative regulation.

Section 7. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs. (1) If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to federal regulation or law, the department shall not reimburse for direct graduate medical education costs.

(2) If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows:

(a) A payment shall be made:

1. Separately from the per discharge and per diem payment methodologies; and

2. On an annual basis corresponding to the hospital's fiscal year; and

(b) The department shall determine an annual payment amount for a hospital as established in subparagraphs 1 through 4 of this paragraph.

1. Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.

2.a. The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Man-

agement Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.

b. The resulting Medicaid utilization factor shall be rounded to six (6) decimals.

3. The total graduate medical education costs referenced in subparagraph 1 of this paragraph shall by multiplied by the Medicaid utilization factor calculated in subparagraph 2 of this paragraph to determine the total graduate medical education costs related to the fee-for-service Medicaid program.

4. Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual payment amount.

Section 8. Reimbursement Updating Procedures. (1)(a) The department shall annually, effective October 1, update the Medicare grouper software to the most current version used by the Medicare program.

(b) If Medicare does not release a new grouper version effective October 1, the current grouper effective prior to October 1 shall remain in effect until a new grouper is released.

(2) At the time of the grouper update referenced in subsection (1) of this section, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.

(3) Annually, on October 1, all values obtained from the Medicare IPPS final rule data tables and impact file shall be updated to reflect the most current Medicare IPPS final rule in effect.

(4) All Medicare IPPS final rule values utilized in this regulation shall be updated to

reflect any correction notices issued by CMS, if applicable.

(5) Except for an appeal in accordance with section 22 of this administrative regulation, the department shall make no other adjustment.

Section 9. Universal Rate Year. (1) A universal rate year shall be established as October 1 of one (1) year through September 30 of the following year.

(2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

Section 10. Cost Reporting Requirements. (1)(a) An in-state hospital participating in the Medicaid Program shall submit to the department, in accordance with the requirements in this section:

1. A copy of each Medicare cost report it submits to CMS;

2. An electronic cost report file (ECR);

3. The Supplemental Medicaid Schedule KMAP-1;

4. The Supplemental Medicaid Schedule KMAP-4; and

5. The Supplemental Medicaid Schedule KMAP-6.

(b) A document listed in paragraph (a) of this subsection shall be submitted:

1. For the fiscal year used by the hospital; and

2. Within five (5) months after the close of the hospital's fiscal year.

(c) Except as provided in subparagraph 1 or 2 of this paragraph, the department shall not grant a cost report submittal extension.

1. If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent

occurrence, the department shall grant a thirty (30) day extension.

(2) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

(3) A cost report submitted by a hospital to the department shall be subject to audit and review.

(4) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

Section 11. Unallowable Costs. (1) The following shall not be allowable cost for Medicaid reimbursement:

(a) A cost associated with a political contribution;

(b) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services. A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(c) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity, subject to the limitations of subparagraphs 1 and 2 of this paragraph.

1. A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.

2. If a meeting is not solely educational, the cost, excluding transportation, shall be

allowable if an educational or training component is included.

(2) A hospital shall identify an unallowable cost on a Supplemental Medicaid Schedule KMAP-1.

(3) A Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted to the department with an annual cost report.

Section 12. Readmissions. (1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

(2) Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Section 13. Reimbursement for Out-of-State Hospitals. (1) The department shall reimburse an acute care out-of-state hospital for inpatient care on a fully prospective per discharge basis except for the following hospitals:

(a) A children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state; and

(b) Vanderbilt Medical Center.

(2) For an inpatient acute care service, except for a service not covered pursuant to 907 KAR 10:012, in an out-of-state acute care hospital the total hospital-specific per discharge payment shall be calculated in the same manner as an in-state hospital as described in section 2(2) of this administrative regulation with modifications to rates used as described in subsections (3) through (7) of this section.

(3) The following DRG payment parameters shall be modified for out-of-state hospi-

tals not specifically excluded in subsection (1) of this section:

(a) The operating rate used in the calculation of the operating base payment described in section 2(4)(c)(1) shall equal the average of all in-state acute care hospital operating rates calculated in accordance with section 2(4)(c) of this regulation multiplied by eighty (80) percent, excluding any adjustments made for:

1. Sole community hospitals pursuant to Section 5 of this administrative regulation; or

2. Medicare-dependent hospitals pursuant to Section 6 of this administrative regulation.

(b) The capital rate used in the calculation of the capital base payment described in section 2(4)(c)(1) shall equal the average of all in-state acute care hospital capital rates calculated in accordance with section 2(4)(c) of this regulation multiplied by eighty (80) percent.

(c) The DRG relative weights used in the calculation of the operating base payment described in section 2(4)(c)(1) and the calculation of the capital base payment described in section 2(4)(c)(1) shall be reduced by twenty (20) percent.

(d) The following provisions shall not be applied:

1. Medicare indirect medical education cost or reimbursement;

2. Organ acquisition cost settlements;

3. Disproportionate share hospital distributions; and

4. Any adjustment mandated for in-state hospitals pursuant to KRS 205.638.

(e) The Medicare operating and capital cost-to-charge ratios used to estimate the cost of each discharge, for purposes of comparing the estimated cost of each discharge

to the outlier threshold, shall be determined by calculating the arithmetic mean of all in-state cost-to-charge ratios established in accordance with section 2(5)(d) of this administrative regulation.

(4) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, the average operating rate and average capital rate paid to in-state children's hospitals.

(5) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center using the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided multiplied by eighty-five (85) percent.

(6) The out-of-state hospitals referenced in subsections (4) and (5) of this section shall not be eligible to receive indirect medical education reimbursement, organ acquisition cost settlements, or disproportionate share hospital payments.

(7)(a) The department shall reimburse a hospital referenced in subsections (4) or (5) of this section a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG.

(b) A cost outlier shall be subject to quality improvement organization review and approval.

(c) The department shall determine the cost outlier threshold for an out-of-state claim regarding a hospital referenced in subsections (4) or (5) using the same method used to determine the cost outlier threshold for an in-state claim.

Section 14. Supplemental Payments. (1) Payment of a supplemental payment established in this section shall be contingent upon the department's receipt of corresponding federal financial participation.

(2) If federal financial participation is not provided to the department for a supplemental payment the department shall not make the supplemental payment.

(3) In accordance with subsections (1) and (2) of this section, the department shall:

(a) In addition to a payment based on a rate developed under Section 2 of this administrative regulation make quarterly supplemental payments to:

1. A hospital that qualifies as an in-state non-state owned pediatric teaching hospital in an amount:

a. Equal to the sum of the hospital's Medicaid shortfall for Medicaid fee-for-service recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

b. Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid fee-for-service recipients under the age of eighteen (18);

2. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

a. Equal to the difference between payments made in accordance with Sections 2 and 7 of this administrative regulation and the amount allowable under 42 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;

b. That is prospectively determined subject to a year-end reconciliation; and

c. Based on the state matching contribution made available for this purpose by a fa-

cility that qualifies under this paragraph; and

3. A hospital that qualifies as an urban trauma center hospital in an amount:

a. Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

b. Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

c. That is prospectively determined with an end of the year settlement; and

d. That is consistent with the requirements of 42 C.F.R. 447.271;

(b) Make quarterly supplemental payments to the Appalachian Regional Hospital system:

1. In an amount that is equal to the lesser of:

a. The difference between what the department pays for inpatient services pursuant to Sections 2 and 7 of this administrative regulation and what Medicare would pay for inpatient services to Medicaid eligible individuals; or

b. $7.5 million per year in aggregate;

2. For a service provided on or after July 1, 2005; and

3. Subject to the availability of coal severance funds, in addition to being subject to the availability of federal financial participation, which supply the state's share to be matched with federal funds; and

(c) Base a quarterly payment to a hospital in the Appalachian Regional Hospital System on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System.

(4) An overpayment made to a hospital under this section shall be recovered by sub-

tracting the overpayment amount from a succeeding year's payment to be made to the hospital.

(5) For the purpose of this section Medicaid patient days shall not include enrollee days.

(6) A payment made under this section shall not duplicate a payment made via 907 KAR 10:820.

(7) A payment made in accordance with this section shall be in compliance with the limitations established in 42 C.F.R. 447.272.

Section 15. Certified Public Expenditures. (1)(a) The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service inpatient service provided during a given state fiscal year via a certified public expenditure (CPE) contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

(b) A payment referenced in paragraph (a) of this subsection shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.

(2) To determine the amount of costs eligible for a CPE, a hospital's allowed charges shall be multiplied by cost-center specific cost-to-charge ratios from the hospital's 2552 cost report.

(3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

(4)(a) Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for

the period.

(b) If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

Section 16. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

(1) The contract shall contain a provision granting the department access:

(a) To the subcontractor's financial information; and

(b) In accordance with 907 KAR 1:672; and

(2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

Section 17. New Provider, Change of Ownership, or Merged Facility. (1) The department shall reimburse a new acute care hospital based on the Medicare IPPS final rule inputs described in this regulation in effect at the time of the hospital's enrollment with the Medicaid program.

(2) If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

(3) If two (2) or more separate entities merge into one (1) organization, the department shall:

(a) Merge the latest available data used for rate setting;

(b) Combine bed utilization statistics, creating a new occupancy ratio;

(c) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

(d) If one (1) of the facilities merging has disproportionate share hospital status and the other does not, retain for the merged facility the status of the facility which reported the highest number of Medicaid days paid; and

(e) Require each provider to submit a cost report for the period:

1. Ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end; and

2. Starting with the day of the merger and ending on the fiscal year end of the merged entity in accordance with Section 10 of this administrative regulation.

Section 18. Department reimbursement for inpatient hospital care shall not exceed the upper payment limit established in 42 C.F.R. 447.271 or 447.272.

Section 19. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 10:012; and

(2) This administrative regulation.

Section 20. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 21. Matters Subject to an Appeal. A hospital may appeal whether the Medicare data specific to the hospital that was extracted by the department in establishing the hospital's reimbursement was the correct data.

Section 22. Appeal Process. (1) An appeal shall comply with the requirements and provisions established in this section of this administrative regulation.

(2)(a) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the department's notice of rates set under this administrative regulation.

(b) The request referenced in paragraph (a) of this subsection shall:

1. Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and

2. Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.

(3)(a) The department shall review the material referenced in subsection (2) of this section and notify the provider of the review results within thirty (30) days of its receipt except as established in paragraph (b) of this subsection.

(b) If the provider requests a review of a non-appealable issue under this administrative regulation, the department shall:

1. Not review the request; and

2. Notify the provider that the review is outside of the scope of this section.

(4)(a) A provider may appeal the result of the department’s review, except for a notification that the review is outside the scope of this section, by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department’s notification of its review decision.

(b) A provider shall not appeal a notification that a review is outside of the scope of

this section.

(5)(a) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(b) Pursuant to KRS 13B.030, the secretary of the Cabinet for Health and Family Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under this administrative regulation.

(c) A notice of the administrative hearing shall comply with KRS 13B.050.

(d) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.

(e) The administrative hearing date may be extended beyond the ninety (90) calendar days by:

1. A mutual agreement by the provider and the department; or

2. A continuance granted by the hearing officer.

(f)1. If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.

2. Conduct of the prehearing conference shall comply with KRS 13B.070.

(g) If a provider does not appear at the hearing on the scheduled date and the hearing has not been previously rescheduled, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).

(h) A hearing request shall be withdrawn only under the following circumstances:

1. The hearing officer receives a written statement from a provider stating that the

request is withdrawn; or

2. A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.

(i) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.

(j) The hearing officer shall:

1. Preside over the hearing; and

2. Conduct the hearing in accordance with KRS 13B.080 and 13B.090.

(k) The provider shall have the burden of proof concerning the appealable issues under this administrative regulation.

(l)1. The hearing officer shall issue a recommended order in accordance with KRS 13B.110.

2. An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110(2) and (3).

(m)1. A final order shall be entered in accordance with KRS 13B.120.

2. The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.

3. In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140 and 13B.150.

Section 23. Effective Date. This administrative regulation shall become effective on October 1, 2015.

Section 24. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Supplemental Medicaid Schedule KMAP-1"; 2013;

(b) "Supplemental Medicaid Schedule KMAP-4", 2013;

(c) "Supplemental Medicaid Schedule KMAP-6", 2013; and

(d) "CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101", June 12, 2009.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) (b) Online at the department’s Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 10:830

REVIEWED:

Date	Lisa Lee, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 10:830

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on April 21, 2015 at 9:00 a.m. in the Health Services Auditorium, Suite C, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by April 14, 2015 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until April 30, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 10:830
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement provisions and requirements for care provided by inpatient acute care hospitals to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse in the same manner as DMS for services provided by an inpatient acute care hospital. This new administrative regulation introduces a new reimbursement model in which DMS's reimbursement shall equate to ninety-five (95) percent of each hospital's Medicare reimbursement excluding certain reimbursement components recognized by Medicare. The excluded components include a Medicare low-volume hospital payment, a Medicare end stage renal disease payment, a Medicare new technology add-on payment, a Medicare routine pass-through payment, a Medicare ancillary pass-through payment, a Medicare value-based purchasing payment or penalty, a Medicare readmission penalty, a Medicare hospital-acquired condition penalty, any type of Medicare payment implemented by Medicare after October 1, 2015, or any type of Medicare payment not described in this administrative regulation. Previously, DMS reimbursed for such care based on a unique diagnosis-related group (DRG) model utilized by DMS.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements for care provided by inpatient acute care hospitals to Medicaid recipients who are not enrolled with a managed care organization. The new reimbursement model is necessary as DMS's current model – a DRG model - is incompatible with the new version of International Statistical Classification of Diseases and Related Health Problems (ICD) systems known as ICD-10. ICD-10 becomes effective on October 1, 2015 and DMS shall be unable to pay for acute care hospital claims effective October 1, 2015 unless it adopts a reimbursement model that is compatible with ICD-10. The Medicare Program reimbursement model for acute care inpatient hospitals is compatible with ICD-10 and is also a model with which Kentucky hospitals are familiar as they provide care to Medicare recipients.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing a reimbursement model for care provided by inpatient acute care hospitals to Medicaid that will be able to pay claims following international adoption of ICD-10.

(d) How this administrative regulation currently assists or shall assist in the effective administration of the statutes: This administrative regulation assists in the effective

administration of the authorizing statutes by establishing a reimbursement model for care provided by inpatient acute care hospitals to Medicaid that will be able to pay claims following international adoption of ICD-10.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment shall change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment shall assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to all inpatient acute care hospitals, Currently, there are approximately sixty-five (65) acute care hospitals participating in the Kentucky Medicaid program.

(4) Provide an analysis of how the entities identified in question (3) shall be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) shall have to take to comply with this administrative regulation or amendment. Hospitals will continue to need to annually submit cost report related documents to DMS.

(b) In complying with this administrative regulation or amendment, how much shall it cost each of the entities identified in question (3): This amendment imposes no cost on the regulated entities.

(c) As a result of compliance, what benefits shall accrue to the entities identified in question (3): Acute care inpatient hospitals will benefit from being able to be reimbursed for hospital care following implementation of ICD-10 and from receiving an additional two (2) million dollars in the aggregate reimbursement pool for care to Medicaid fee-for-service recipients.

(5) Provide an estimate of how much it shall cost to implement this administrative regulation:

(a) Initially: DMS estimates that implementing the administrative regulation will increase DMS expenditures by $1.5 million ($1.05 million federal funds and $0.45 million state funds) for the state fiscal year ending June 30, 2016 and by another $0.5 million ($0.35 million federal funds and $0.15 million in state funds) for the first three (3) months of the subsequent state fiscal year.

(b) On a continuing basis: DMS estimates that the expenditure increase described in paragraph (a) will plateau for future years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding shall be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding shall be necessary to implement the amendment to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the amendment applies to all regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 10:830
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30) and 42 C.F.R.447.205.

2. State compliance standards. KRS 205.520(3) states, “to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:
“. . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

   42 C.F.R. 447.205 mandates that the state provide public notice of reimbursement changes.

4. Shall this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal standard.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 10:830
Agency Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) shall be impacted by this administrative regulation? The Department for Medicaid Services (DMS) shall be impacted by the amendment.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), and 42 U.S.C. 1396a(a)(30).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue shall this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates no revenue above the current revenue level being generated for the first year for state or local government due to the amendment to this administrative regulation.
(b) How much revenue shall this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue above the current revenue level being generated in subsequent years for state or local government due to the amendment to this administrative regulation.
(c) How much shall it cost to administer this program for the first year? The amendment does not result in additional costs to the Department for Medicaid Services for the first year.
(d) How much shall it cost to administer this program for subsequent years? The amendment does not result in additional costs to the Department for Medicaid Services for subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): ____
Expenditures (+/-): ____
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 10:830

Summary of Material Incorporated by Reference

(1) The “Supplemental Medicaid Schedule KMAP-1”, 2013 is a form currently incorporated by reference that is being revised. The 2013 replaces the January 2007. This one (1) page form is used by participating hospitals to report various hospital costs. Revisions include changing the instructions in column 2 to refer to the current line numbers on the Medicare Cost Report Worksheet B.

(2) The “Supplemental Medicaid Schedule KMAP-4”, 2013 is also a form currently incorporated by reference that is being revised. The 2013 replaces the January 2007. This one (1) page form is a questionnaire used by participating hospitals to report information regarding disproportionate share hospital care. The form was revised to state the edition date as being 2013 rather than January 2007.

(3) “Supplemental Medicaid Schedule KMAP-6”, 2013 is a new one (1) page form that is also used by participating hospitals to report costs related to labor-delivery rooms and nurseries.

(4) The “CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101”; June 12, 2009 edition is an eleven (11)-page document establishing procedures, services, or hospitalizations known as never events which are not reimbursable by the Centers for Medicare and Medicaid Services (CMS). The Department for Medicaid Services (DMS) is mirroring the CMS policy regarding these procedures, services, or hospitalizations.

A total of fourteen (14) pages are incorporated by reference.